

**APPLICATION FOR SCL WAIVER AND ICF/MR SERVICES***Read attached instruction sheet before completing this application***Section 1**Sex: M ☐ or F ☐Name \_\_\_\_\_  
First Middle Last

Social Security Number \_\_\_\_\_ Medical Assistance Number \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_  
month day yearPresent Address \_\_\_\_\_  
Street  
City County State Zip Code**Section 2**

Legal Representative/Guardian \_\_\_\_\_

Address \_\_\_\_\_

City County State Zip Code

Phone \_\_\_\_\_ Relationship to Applicant \_\_\_\_\_  
(Ex: mother, father, friend)

Legal Rep./Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

**Section 3**Case Management Provider Name  
and Address

Name \_\_\_\_\_

Address \_\_\_\_\_

City County State Zip Code Phone Number

**Section 4**

DSM Diagnosis:

Axis I (Mental Health): \_\_\_\_\_

Axis II (Mental Retardation/Developmental Disability) : \_\_\_\_\_

Axis III (Physical Health): \_\_\_\_\_

Age Disability Identified: \_\_\_\_\_

Physician/QMRP Signature \_\_\_\_\_

Date \_\_\_\_\_

☐ SCL Waiver

CMHC MR/DD Director Signature \_\_\_\_\_

Date \_\_\_\_\_

☐ ICF/MR**Section 5**

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_

PLEASE TELL US ABOUT THE APPLICANT BY CHECKING ONE BOX UNDER EACH HEADING.

## 6. MOBILITY

- ☐ Walks independently
- ☐ Walks with supportive devices
- ☐ Walks unaided with difficulty
- ☐ Uses wheelchair operated by self
- ☐ Uses wheelchair & needs help
- ☐ No mobility

Comments: \_\_\_\_\_

## 7. COMMUNICATION

- ☐ Speaks and can be understood
- ☐ Speaks and is difficult to understand
- ☐ Uses gestures
- ☐ Uses sign language
- ☐ Uses communication board or device
- ☐ Does not communicate

Comments: \_\_\_\_\_

## 8. HOW MUCH TIME IS REQUIRED FOR ASSURING SAFETY?

- ☐ Requires less than 8 hours per day on average
- ☐ Requires 9-16 hours daily on average
- ☐ Requires 24 hours (does not require awake person overnight)
- ☐ Requires 24 hours with awake person overnight
- ☐ **Extreme Need:** Requires 24 hours, awake person trained to meet individual's particular needs; continuous monitoring

COMMENTS: \_\_\_\_\_

## 9. HOW MUCH ASSISTANCE IS NEEDED FOR DAILY LIVING TASKS? (Choose only ONE box)

- ☐ **No assistance** needed in **most** self-help and daily living areas, and **Minimal assistance** (*use of verbal prompts or gestures as reminders*) needed in **some** self-help and daily living areas, and **Minimal to complex assistance** needed to complete complex skills such as financial planning and health planning.

- ☐ **No assistance** in **some** self-help, daily living areas, and **Minimal assistance** for many skills, and **Complete assistance** (*caregiver completes all parts of task*) needed in **some** basic skills and all **complex** skills.

- ☐ **Partial** (*use of hands on guidance for part of task*) to complete assistance needed in **most** areas of self-help, daily living, and decision making, and Cannot complete **complex** skills.

- ☐ **Partial to complete assistance** is needed in **all areas** of self-help, daily living, decision making, and complex skills

- ☐ **Extreme Need:** All tasks must be done for the individual, with no participation from the individual

**10. HOW OFTEN ARE DOCTOR VISITS NEEDED?**

- ☐ For routine health care only / once per year  
☐ 2-4 times per year for consultation or treatment for chronic health care need  
☐ More than 4 times per year for consultation or treatment  
☐ **Extreme Need:** Chronic medical condition requires immediate availability and frequent monitoring

COMMENTS: \_\_\_\_\_

**11. HOW OFTEN ARE NURSING SERVICES NEEDED?**

- ☐ Not at all  
☐ For routine health care only  
☐ 1-3 times per month  
☐ Weekly  
☐ Daily  
☐ **Extreme Need:** Several times daily or continuous availability

COMMENTS: \_\_\_\_\_

**12. ARE THERE BEHAVIORAL PROBLEMS?** Yes ☐ No ☐**IF YES-PLEASE CHECK ALL THAT APPLY.**

- ☐ Self Injury  
☐ Aggressive towards others  
☐ Inappropriate sexual behavior  
☐ Property destruction  
☐ Life threatening (threat of death or severe injury to self or others)  
☐ Takes prescribed medications for behavior control

**PLEASE CHECK ONE ANSWER UNDER EACH QUESTION, UNLESS OTHERWISE INDICATED.**

**13. WHERE IS THE INDIVIDUAL CURRENTLY LIVING?**

- |                                                              |                                                          |                                               |
|--------------------------------------------------------------|----------------------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Living with family/relative         | <input type="checkbox"/> Living in own home or apartment | <input type="checkbox"/> Foster Care          |
| <input type="checkbox"/> Group home or personal care home    | <input type="checkbox"/> Nursing home                    | <input type="checkbox"/> Psychiatric Facility |
| <input type="checkbox"/> ICF/MR (Intermediate Care Facility) | <input type="checkbox"/> Living with a friend            | <input type="checkbox"/> Other _____          |

**14. DOES THE INDIVIDUAL CURRENTLY RECEIVE ANY OF THE FOLLOWING SERVICES? (CHECK ALL THAT APPLY)**

- |                                                         |                                                                                               |
|---------------------------------------------------------|-----------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Supported Living               | <input type="checkbox"/> Medicaid EPSDT (if under 21)                                         |
| <input type="checkbox"/> Medicaid Acquired Brain Injury | <input type="checkbox"/> Medicaid Home & Community Based Waiver                               |
| <input type="checkbox"/> Supported Employment           | <input type="checkbox"/> Mental Health Counseling or Medication for a mental health condition |
| <input type="checkbox"/> Home Health                    | <input type="checkbox"/> In home Support                                                      |
| <input type="checkbox"/> Other Medicaid Services        | <input type="checkbox"/> Residential                                                          |
| <input type="checkbox"/> Day Program                    | <input type="checkbox"/> Respite                                                              |
| <input type="checkbox"/> School                         | <input type="checkbox"/> Occupational Therapy                                                 |
| <input type="checkbox"/> Behavior Support               | <input type="checkbox"/> Case Management                                                      |
| <input type="checkbox"/> Transportation                 | <input type="checkbox"/> Other _____                                                          |
| <input type="checkbox"/> Speech Therapy                 |                                                                                               |
| <input type="checkbox"/> Physical Therapy               |                                                                                               |

**15. WHAT SERVICES ARE NEEDED NOW OR IN THE FUTURE?**

- |                                           |                                               |
|-------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Day Program      | <input type="checkbox"/> In home Support      |
| <input type="checkbox"/> School           | <input type="checkbox"/> Residential          |
| <input type="checkbox"/> Respite          | <input type="checkbox"/> Behavior Support     |
| <input type="checkbox"/> Transportation   | <input type="checkbox"/> Occupational Therapy |
| <input type="checkbox"/> Speech Therapy   | <input type="checkbox"/> Case Management      |
| <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Supported Employment |

**16. THE FOLLOWING ARE 5 CHOICES FOR FUTURE LIVING ARRANGEMENTS. WHERE WOULD THE APPLICANT PREFER TO LIVE IN THE FUTURE? CHOOSE ONLY ONE (1):**

- ☐ At home with a family member with someone to come in and help  
☐ In the person's own home with minimal supports  
☐ In a 24 hour staffed residence in the community  
☐ In a 24 hour supervised family home in the community  
☐ In a 24 hour staffed group home in the community  
☐ In an ICF/MR

**17. WHO IS THE PRIMARY CAREGIVER? (If staff, do not answer questions 18 & 19.)**

- ☐ Mother    ☐ Father    ☐ Grandmother    ☐ Grandfather    ☐ Aunt    ☐ Uncle    ☐ Staff  
☐ Sister    ☐ Brother    ☐ Friend    ☐ Neighbor    ☐ Other: Who? \_\_\_\_\_

**18. WHAT IS THE AGE OF THE PRIMARY CAREGIVER?**

- ☐ Less than 30 years old    ☐ 31-50 years old    ☐ 51-60 years old    ☐ 61-70 years old  
☐ 71-80 years old    ☐ Over 80 years old

**19. THE PRIMARY CAREGIVER'S HEALTH STATUS COULD BE CLASSIFIED AS:**

- ☐ Poor    ☐ Stable    ☐ Good    ☐ Very Good

Comments: \_\_\_\_\_

Person Completing Application: \_\_\_\_\_

Print Name

Relationship to Individual (if not individual)

Phone Number

Signature

Date

Additional Comments: \_\_\_\_\_

**Mail to: The Division of Mental Retardation, 100 Fair Oaks Lane, 4W-C, Frankfort, KY. 40621**